after moving on to the Officer's Staff as Press Secretary, First Vice President and Secretary Treasurer of the 16,000-member local for more than 20 years. He was a charter member and President of the Hunterdon-Warren Counties Central Labor Council for four years, after which he was elected President of the Monmouth-Ocean Counties Central Labor Council.

Some of the other responsibilities Steve Hornik holds or has held, representing labor, include: Chairman of the Rutgers University Trade Union Consulting Council, the Monmouth County Workforce Investment Board, United Way of Tri-State Board of Governors, and a Commissioner on the Governor's Employment and Training Commission. He is also on the Advisory Boards of Brookdale College, Monmouth University and is a member of the State Board of Arbitration and Mediation. He was previously on the Executive Board of the New Jersey Central and State Lung Associations, a Member of New Jersey Chief Justice Robert N. Wilentz's Courts Committee on Efficiency, the Private Industry Council, the Congressional Award Council and the Manalapan Democratic Club. He has been a member of numerous State and County screening committees, and was a delegate to four of the last five Democratic Conventions. He remains a County Committee Member, a position he has held for the last 35 years. He has been and continues to be active with the Knight of Columbus.

Steven Hornik is also a devoted family man. He and his wife Arline have four grown children and 10 grandchildren.

Mr. Speaker, I could go on and on, talking about my good friend Steve Hornik, citing his many accomplishments on behalf of working people and his many contributions to our community. At the testimonial in his honor later this month, many of these great accomplishments will be recounted, happy memories recalled and funny stories told. We will miss his hard work, his energy and his honest dedication to fighting for the interests of working people.

Mr. Speaker, labor unions have achieved many important victories over the years, fighting for safe working conditions, living wages, health care benefits and a dignified retirement. The battles fought and won by the labor movement have not only helped union members. America's broad-based economic growth, the expansion of the middle class, the existence of programs like Social Security and Medicare, and the realization of the American dream for tens of millions of families all owe a tremendous debt of gratitude to labor unions. These days, unions are under attack. But I believe public support is still strong. I know that the unions will continue to fight for such basic rights as universal health care coverage, increased pension security and fair trade agreements that protect American jobs. It's great leaders like Steve Hornik who have made, and continue to make, the union movement strong.

I regret that Steve Hornik will no longer be at the helm of the Monmouth-Ocean Central Labor Council. But I know that we will continue to benefit from his contributions to the ongoing fight for social and economic justice for working people. Steve Hornik has contributed to that fight more than anybody I know. The example that he set will guide us all for years to come.

TRIBUTE TO ISAAC DARKO

HON. JOSÉ E. SERRANO

OF NEW YORK

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 5, 1998

Mr. SERRANO. Mr. Speaker, I rise to congratulate and to pay tribute to Mr. Isaac Darko, a constituent of mine and a distinguished student at Columbia University in New York. He will be recognized for his academic and scientific achievements as a participant in the National institutes of Health (NIH) Undergraduate Scholarship Program for Individuals from Disadvantaged Backgrounds (UGSP) on August 6, 1998.

Isaac graduated from the Health Professions and Human Services High School in 1997 and has just completed his freshman year at Columbia University. This summer he has been working at the NIH Department of Molecular Biology under the supervision of Dr. Alfred Johnson. He has been working on the epidermal growth factor receptor (EGFR), which is expressed in such cancers as breast and prostate cancer and in other cancer cell lines.

Mr. Speaker, the UGSP scholars search is highly competitive and nationwide. Currently, the program has 24 scholars from all over the nation, from institutions such as Columbia University, MIT, Harvard, Georgetown, U.C. Davis, and Stanford. In order to participate in the program, a Scholar must either have a 3.5 Grade Point Average or be in the top 5% of his/her class. Candidates must also demonstrate a commitment to pursuing careers in biomedical research and must be from a disadvantaged background. The current group is composed of 32% Hispanics, 32% African Americans, 21% Asians, 10% Caucasians, and 5% Native American, with a balance between the genders of 52% female and 48% male.

Mr. Speaker, being selected for this program indicates that Isaac has demonstrated that he has the ability and the desire to be an asset and a role model in our community. We are proud of his accomplishments and I know he is taking full advantage of the opportunity presented to him. He is a terrific example for future participants in this program and others like it.

Mr. Speaker, I ask my colleagues to join me in congratulating Mr. Isaac Darko for his outstanding accomplishments and also in commending the National Institutes of Health Undergraduate Scholarship Program for Individuals from Disadvantaged Backgrounds for offering opportunities to students like Isaac.

PERSONAL EXPLANATION

HON. JO ANN EMERSON

OF MISSOURI

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 5, 1998

Mrs. EMERSON. Mr. Speaker, I rise to clarify my vote on Roll Call vote 384, Mr. BASS' amendment to the Commerce, State, Justice, and the Judiciary Appropriations bill. Yesterday, I inadvertently voted ''nay'' when I intended to vote ''aye''.

Mr. BASS' amendment would have transferred funds from the Advanced Technology Program (ATP) to the Edward Byrne grant program at the Department of Justice, an effort which I strongly support. The Byrne grant program is a valuable tool for local law enforcement in the fight against the crime and drug problems that threaten our neighborhoods. I believe that scarce taxpayer dollars are better spent in this anti-crime program than in the ''corporate welfare'' ATP, which I have consistently opposed.

INTRODUCTION OF LEGISLATION TO ENSURE PROMPT CLAIM PAYMENT BY HEALTH PLANS

HON. JIM McDERMOTT

OF WASHINGTON

IN THE HOUSE OF REPRESENTATIVES

Wednesday, August 5, 1998

Mr. McDERMOTT. Mr. Speaker, today I am introducing legislation that addresses the issue of prompt payment, that is, ensuring health plans reimburse providers in a timely manner.

Although there have been numerous horror stories of health plans withholding reimbursement from providers the issue of prompt claim payment has not been addressed during the managed care reform debate.

My view is that the prolonged delay of claim payments by health plans interferes with the doctor-patient relationship.

By delaying reimbursements to doctors, health plans are turning care-givers into bill collectors—forcing them to hound both the insurance company and the patient for reimbursements which, in most cases, should already have been paid by the plan.

Unnecessary reimbursement delays by health plans create unnecessary rifts between the patient and the provider—causing confusion with patients about their health insurance plan at a time when they are most vulnerable and possibly even distrust by the patient in the quality of their provider.

The attached article from the August 2, 1998 Washington Post elaborates with specific, real life examples of the above mentioned issues.

Medicare, Medicare+Choice, & Medicaid already have statutory language requiring prompt payment by its contractors. Yet, when President Clinton extended managed care protections to federal employee health plans, he did not include the prompt payment language in his executive order.

Because of federal inaction, some states have taken the lead in this area. Texas, Florida, Tennessee, New York, and New Jersey have stat laws requiring prompt payment. Similar bills have been introduced in Georgia, Massachusetts, New Jersey, Oklahoma, Pennsylvania, Rhode Island, Vermont and Washington.

Most of the state laws appear stricter than the Medicare+Choice model I propose. For example, in addition to establishing clean claim payment guidelines, Texas requires strict time lines for plans when notifying a provider that a claim is being investigated. The plan must explain in writing why they reject a claim, and make payments in 5 business days after notifying claimants that their claim will be paid.

New York, home of the infamous Oxford Health Plan, has by far the strongest penalties for plans that fail to comply with their prompt payment laws. New York plans can be subject

to fines of up to $500 per day for each claim not paid within 345 days.

Rather than draft comprehensive legislation this year that includes stronger guidelines than are currently in place at the federal level, I chose to introduce legislation that simply applies the existing Medicare+Choice prompt payment regulations to all health plans—regulations that Congress overwhelmingly supported last year.

If enacted, my legislation requires health plans to pay 95% of the clean claims within 30 days of receipt. If health plans do not comply with these guidelines, the bill requires plans to pay interest on clean claims that are not paid within 30 days. The legislation also requires that all other claims must be approved or denied within 60 calendar days from the date of the request.

Congress can begin to address this important issue and alleviate much of the stress health plans are causing both patients and providers by passing prompt payment legislation. I urge my colleagues to join me in taking action on this issue this year.

[From the Washington Post, August 2, 1998]

HEALTH CARE'S PAINFUL CLAIMS—PROBLEMS WITH INSURERS PLAGUE MANY PATIENTS

(By David S. Hilzenrath)

Olney resident Tammy L. Rhoades's health insurer, Blue Cross and Blue Shield of the National Capital Area, left her on the hook for $384 of anesthesiology charges because the doctor who administered pain relief while she was in labor wasn't a ''preferred provider.''

Baltimore resident William F. Cooke's insurer refused to pay $1,404 for respiratory therapy he received after being diagnosed with lung disease. Cooke said he checked with Blue Cross and Blue Shield of Maryland before he started treatment. But the company rejected the bills, saying his policy's stated coverage of ''physical therapy'' didn't mean ''respiratory therapy.''

David Trebach of Alexandria received notice in June that a doctor's office would obtain a court summons and ''an immediate judgment against you and your property'' if he didn't pay hundreds of dollars of bills dating back as far as June 1997. Despite Trebach's persistent pleas, Kaiser Permanente had failed to pay.

Eventually, each of the insurers gave in to protests and paid the bulk of the charges, which erased the customers' debts, but not their resentment.

For a growing number of consumers, it has become a familiar test: exasperating rounds of letters, phone calls and time spent on hold; empty corporate assurances, mysterious delays and bewildering rebuffs—all in the course of getting a health insurance company to pay what they contend it should have paid in the first place.

''There is general misery in all dealings,'' Maryland Insurance Commissioner Steven B. Larsen said.

Though some insurance companies, such as Kaiser Permanente, acknowledged lapses in service, others, such as CareFirst Inc., say they pay the vast majority of claims without a hitch.

Conflicts between health insurers and patients are hardly a new phenomenon, but the upheaval in the nation's health care system in recent years has raised the level of frustration. The managed care revolution, which promised to simplify billing for consumers, instead has spawned bureaucratic rules and procedures so complex that they have confounded even the latest computer systems—not to mention human beings.

Problems with ''billing or payment of claims or premiums'' tied as the top health insurance complaint of Californians surveyed last fall by a state health policy task force. Fourteen percent said those relatively pedestrian issues were their biggest health insurance problem, eclipsing such hotly debated issues as delays in obtaining needed care or difficulty getting referrals to specialists.

Some rapidly growing health plans have overreached, adding members much faster than they have added workers. Others have thrown their customer service into chaos, at least temporarily, by merging with companies that use different systems, consolidating far-flung offices, laying off experienced employees in one part of the country and hiring novices to replace them somewhere else—all in the name of efficiency.

''Most plans today are having serious servicing issues—issues of turnaround time, accuracy, being able to respond to consumers,'' said Richard Sinni of Watson Wyatt Worldwide, which audits health plan performance for employers. ''I think they've gotten worse across the board.''

Many doctors, hospitals and patients accuse insurers of dragging out payments as part of a deliberate strategy to wear them down or continue earning interest on their money as long as possible.

Insurers deny that the delays are intentional. They attribute them to a variety of factors, including their own administrative errors, patients' ignorance about their benefits and necessary enforcement of sometimes unpopular standards.

This much is clear: The industry's heightened focus on the bottom line means bills these days are subject to stricter scrutiny and challenge.

''We do not apologize aggressive approach to . . . utilization review on behalf of our members,'' William L. Jews, chief executive of CareFirst, said in a news release last week.

CareFirst, parent of the Blue Cross and Blue Shield companies serving Maryland and the District, has a duty to make sure customers' health dare dollars are spent responsibly, executives said. The insurer is also caught between conflicting expectations—those of the people who receive the care and those of the employers who subsidize it, officials said.

''The employers . . . ask Blue Cross to be stricter or harder or harsher on payments,'' said John Moseman, a vice president of the Maryland company.

Often, doctors and patients create their own headaches by filling out forms incorrectly or ignoring the rules.

One woman had about $9,000 of maternity charges rejected last year because she didn't get the required ''precertification'' for the birth of her child, said Dora Crouse, whose job is to troubleshoot claims problems for clients of JEMM Group Insurance Inc., a Silver Spring insurance broker. When JEMM intervened, the woman's preferred provider organization agreed to pay the bills.

In contrast, no one blames Bonnie Emmert of Grant Junction, Colo., for her woes, but it took several months and the involvement of state regulators to resolve them.

While undergoing chemotherapy and radiation this year for breast cancer, Emmert said she spent much of her time listening to the music on her insurer's customer service line, faxing and mailing multiple copies of the same paperwork, and fending off demands by her hospital and doctors for payment of charges dating back as far as December. A nurse by profession, Emmert said she has been living off savings while sidelined by her illness.

Provident American Life and Health Insurance Co., based in Norristown, Pa., was investigating Emmert's medical history to determine if her cancer was a preexisting condition and therefore excluded from coverage.

Emmert, 45, who bought her Provider policy last August and had surgery in December, said she found the company's doubts hard to understand. ''I had cancer in August and I waited till December to do anything about it?'' she asked, rhetorically. ''Yeah, right.''

The bills came due just in time to get caught in the confusion when Provident moved its claims processing operations from Minnesota and Pennsylvania to Florida in late January. ''The data transfer did not go smoothly,'' said Jimmy Potts, Provident's vice president for market conduct and compliance. The move ''created a delay that is frankly unacceptable to the company, but under the circumstances was unavoidable.''

Following the move, Provident was so overwhelmed with inquiries about delayed payments that callers were left on hold for as much as an hour and a half at a time, Potts said.

The company agreed to pay thousands of dollars for Emmert's care on July 8 after the Colorado Division of Insurance showed that she had been insured before she bought coverage from Provident. That made any question of a preexisting condition moot, Potts said.

''We recognize it's a frustrating time for her,'' Potts said. ''But it also has been an incredibly frustrating time for those of us within the insurance company.''

William Cooke's sentiments in his dispute with Blue Cross and Blue Shield of Maryland went beyond frustration. In a complaint to the Maryland Insurance Administration (MIA), the Baltimore retail manager accused the company of ''predatory'' behavior.

Blue Cross defended its decision not to pay for Cooke's respiratory therapy in an August 1997 letter to the MIA, noting that Cooke's policy explicitly excluded ''admissions or any period of stay in a facility'' for various services.

The relevance of that was hard to fathom, because Cooke said he received the therapy on an outpatient basis.

Months later, Blue Cross continued to argue that, while Cooke's policy covered ''physical therapy,'' the treatment he received didn't fit the definition.

The MIA disagreed. In March, it wrote that the company's posture ''may violate general quality of care standards.''

Even then Blue Cross held its ground, so in April the MIA issued an ultimatum: Failure to pay would result in a formal order against the company ''and administrative penalties.''

Finally, in late June—more than a year and half after the disputed treatment ended—Blue Cross paid $1,303.25.

In the case of Rhoades and her out-of-network anesthesiologist, the insurer reversed itself without argument.

''We would agree with Mrs. Rhoades's position that she could not at the time of the delivery as the question . . . 'Are you [a preferred provider] or are you not?'' Moseman said.

Though the nation's angst over medical claims is hard to measure, signs of it abound:

Fast-growing Oxford Health Plans Inc. of Norwalk, Conn., developed what it envisioned as a state-of-the-art computer system—and then watched it malfunction on a grand scale. Doctors, hospitals and regulators complained about a mountain of unpaid medical bills. To make amends, the company had advanced $203 million to health care providers as of Dec. 31 as it attempted to plow through the backlog.

After Aetna Inc. merged with U.S. Healthcare, the amount of time it took to

company to process medical claims doubled last year, according to one analyst. The company says performance has since rebounded.

What had been 44 claims-processing centers across the country were consolidated at about 25 locations, and the number of employees handling claims was reduced by more than one-fifth. Employees with 15 years of experience were replaced by people with less than a year's experience, said R. Max Gould, Aetna U.S. Healthcare's head of customer service.

In a series of audits of Colorado health insurers, the state Division of Insurance has cited widespread problems related to payment of claims, among other shortcomings. The regulatory agency this year assessed fines against PacifiCare of Colorado Inc., HMO Colorado Inc., Blue Cross Blue Shield of Colorado and Gem Insurance Co.

Gem, which tripled enrollment in three years and accumulated a backlog of 106,000 unpaid claims, said in June that its low prices ''led to . . . poor customer service.''

When Prudential moved processing of many Washington area claims to Jacksonville, Fla., in the spring of 1997 ''initially there was some conversion disruption,'' Prudential spokeswoman Peggy Frank Lyle said. The company was compressing 40 claims-processing sites and 28 member-services sites nationwide into four.

It's ''very difficult when you have that many new people to train,'' Lyle said.

In April, Maryland's hospitals filed a coordinated complaint with the state insurance commissioner alleging health plans were systematically denying payment for medically necessary care after the care had been delivered.

United Healthcare, though not singled out for criticism, showed the highest level of denied claims, according to Maryland Hospital Association data. The percentage of hospital days for which it initially refused payment rose to 14.6 percent in 1997—more than one in seven—from 4.4 percent in 1996, the association reported.

''When we find the care is not appropriate, we deny [payment for] the hospital day,'' United Healthcare Vice President Sharon Pavlos said.

Kaiser Foundation Health Plan of the Mid-Atlantic States Inc., also know as Kaiser Permanente, in June paid $117,000 to settle an array of potential violations cited by the Virginia Bureau of Insurance.

For example, more than one-fifth of the time, a review found, Kaiser failed to add interest to late claim payments as required by law.

Kaiser said its problems got much worse last year, after the period covered by the review. The February 1997 takeover of Humana Group Health Inc., ''crashed our little system'' said Bernard J. Tyson, president of Kaiser's Central East Division. ''We don't have . . . the right infrastructure and information systems to manage now a big piece of our business.''

The company plans to complete a major upgrade next spring. In the meantime, it fired the outside contractor that had been handling its claims and switched to a better internal system, officials said. ''Clean'' claims, which are claims that don't raise questions, were being processed in an average of 26.7 days during June, compared with about 50 days at one point last year.

Trebach's most severely delayed bills ''fell in some black hole,'' spokeswoman Darlene Frank said.

For Trebach, a social worker in the Fairfax County public schools, a final indignity was the doctors' warning that a ''warrant in debt'' might be ''delivered to your home by a Sheriff.''

''This would be so frightening for my children,'' said Trebach's wife, Loretta DiGennaro.

Consumers ignore payment demands at their peril, as a clerk in a Washington electrical supply business recently discovered. Long after his insurer had rejected a series of 1995 and 1996 hospitals bills—so much later that the insurer can't document the reason—the hospital turned them over to a collection agency, according to Crouse at the JEMM insurance brokerage.

Now, under a court order, the clerk's wages are being garnisheed to pay the debt.

DEPARTMENTS OF COMMERCE, JUSTICE, AND STATE, AND JUDICIARY, AND RELATED AGENCIES APPROPRIATIONS ACT, 1999

SPEECH OF

HON. CONSTANCE A. MORELLA

OF MARYLAND

IN THE HOUSE OF REPRESENTATIVES

Tuesday, August 4, 1998

The House in Committee of the Whole House on the State of the Union had under consideration the bill (H.R. 4276) making appropriations for the Department of Commerce, Justice, and State, the Judiciary, and related agencies for the fiscal year ending September 30, 1999, and for other purposes.

Mrs. MORELLA. Mr. Chairman, I rise in opposition to the amendment offered by my friend from Maryland.

My friend and neighbor Mr. BARTLETT argues that it is actually the U.N. which owes us money. Nothing could be further from the truth. The figures which he cites from the GAO include costs of non-U.N. peacekeeping operations undertaken by the United States in our own national interest, such as the Gulf War and our operations in Bosnia and Haiti, as well as Somalia.

Every living former Secretary of State opposes the Bartlett amendment, including James Baker, Alexander Haig, George Schultz, and Henry Kissinger. This is hardly a bunch of free-spending, bleeding-heart liberals out to hand over U.S. sovereignty. They support U.N. funding not only because it is a legal obligation, but because it serves our national interest in contributing to global peace, prosperity and security, and because it serves our humanitarian interests in assisting refugees, improving human rights, and establishing the rule of law. Our continued failure to honor our obligations threatens our interests by threatening the U.N.'s financial and political viability.

Many of us recognize the need for U.N. reform. But these efforts are hampered, not helped, by the current U.N. financial problem. We have been trying to reduce our U.N. budget share, but negotiations ended last year when other members would not agree to pay more until the U.S. paid at least its current obligated share. As the former Secretaries have noted, ''without a U.S. commitment to pay arrears . . . U.S. efforts to consolidate and advance U.N. reforms and reduce U.S. assessments are not going to succeed.''

I urge a ''no'' vote on the Bartlett amendment.